

The Estate Planning Advisor

Does Medicare Cover Nursing Home Costs?

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The typical conversation regarding long-term care costs concerns how a person may obtain Medicaid coverage for long-term care costs. This article, however, addresses the role that *Medicare* plays in long-term care financing.

Medicare provides *limited* coverage for nursing home stays if, and only if, the following requirements are satisfied: (1) the patient is hospitalized at least three consecutive days excluding the day of discharge; (2) the nursing home admission takes place within thirty days of the hospital discharge (with limited exceptions); (3) the patient requires skilled nursing or skilled rehabilitation services, or both, and such services can be provided only in a skilled nursing facility on an in-patient basis; (4) the services are provided for a condition that was treated in the hospital; and (5) the patient's stay is approved by the facility's peer review committee.

It is the fifth condition that tends to prove most difficult. If the facility's admission review committee determines that the care to be provided is not skilled or rehabilitative, but rather is custodial care only, Medicare coverage will be denied. Even when a patient obtains Medicare approval for a long-term care stay, Medicare will pay for a *maximum* coverage period of 100 days. Of the 100-day maximum coverage period, only the first 20 days would be covered at 100% of the cost; for days 21-100, the patient is responsible for a co-pay amount that presently stands at \$124 per day.

Even when a nursing home patient receives initial Medicare approval, the coverage may be revoked anytime during the 100-day coverage period if Medicare determines that the patient no longer requires skilled nursing or rehabilitation care. If Medicare does in fact determine that coverage will be terminated, the patient has the right to appeal the decision before an independent administrative law judge.

A thorny issue often arises when a patient is being discharged from a hospital to a nursing home for skilled nursing or rehabilitative care and the prospective nursing home requires the patient (or their family) to place a security deposit upon entry. Federal law prohibits requiring a security deposit as a condition for nursing home admission for any patient who is technically eligible for Medicare – that is, a patient who is over the age of 65 and who has been hospitalized for at least 3 days prior to admission to the nursing home. This rule applies even if the patient cannot realistically benefit from skilled nursing or rehabilitative care, since an actual determination of Medicare eligibility can be made only *after* the patient has been admitted and their care needs evaluated.

Notwithstanding the legal requirements, many nursing homes require a deposit equal to the cost of three months of nursing home care prior to accepting a patient.

Families who desire a specific nursing home placement are often left with no practical alternative to paying the security upon admission of their loved-one.

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